Clear Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/22/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
cervical ESI C5-6

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. The reviewer finds the requested cervical ESI C5-6 is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 07/13/12, 07/19/12
Orders dated 07/27/12, 06/29/12, 04/26/12
Office visit note dated 07/27/12, 06/29/12, 04/26/12, 03/23/12, 01/26/12, 01/12/12, 12/22/11
MRI cervical spine dated 01/23/12
Operative report dated 02/21/12
CT myelogram dated 04/09/12
EMG/NCV dated 04/17/12
Radiographic report dated 12/22/11, 12/06/11
Progress note dated 12/13/11

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female whose date of injury is. She tripped on tape on the carpet and fell backwards. She reports undergoing a lumbar fusion 15 years ago for previous lower back problems. MRI of the cervical spine dated 01/23/12 revealed mild narrowing and desiccation of the interspace at C5-6 with evidence of mild bulging of the disc that produces some compression in the neural foramina in the right. The facets are normal. The patient underwent cervical epidural steroid injection at C5-6 on 02/21/12. Follow up note dated 03/23/12 indicates that the injection helped for 1-2 weeks, but the pain has returned. CT myelogram dated 04/09/12 revealed mild spondylitic changes with mild broad based disc bulge/disc protrusion at C5-6. EMG/NCV dated 04/17/12 was normal. There is moderate to severe right carpal tunnel syndrome. Physical examination on 06/29/12 indicates motor

strength is normal in the upper and lower extremities. Sensation is normal in the upper and lower extremities. There is numbness in the hands to compression of the palmar aspect of the wrist; otherwise the joints in the upper extremities show no evidence of tenderness, effusion, instability, contractures or crepitus. Cervical range of motion is limited, but does not reproduce a radiculopathic symptom.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The submitted physical examination does not support a diagnosis of radiculopathy. The patient's physical examination reveals intact motor strength and sensation throughout the bilateral upper extremities. CT of the cervical spine performed on 04/09/12 revealed that there is no spinal stenosis at any level. The submitted records also state that the patient underwent an initial cervical epidural steroid injection at C5-6 on 02/21/12. Follow up note dated 03/23/12 indicates that the injection helped for 1-2 weeks, but the pain has returned. The Official Disability Guidelines require documentation of at least 50% pain relief for 6-8 weeks prior to the performance of a repeat epidural steroid injection. The reviewer finds the requested cervical ESI C5-6 is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)